General Assembly **Substitute Bill No. 1353**

January Session, 2005 *____SB01353PH_APP040405___*

AN ACT EXPANDING THE AVAILABILITY OF HEALTH INSURANCE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2005*) (a) As used in sections 1 to 3, inclusive, of this act:

(1) "Administrative services fee" means any required payment made by an individual for the purpose of defraying the administrative costs of the plan;

(2) "Capitation" means a payment system in which enrollees pay a fixed monthly fee to a managed care organization in return for the provision of a specific range of services for a contract year;

(3) "Coinsurance" means the sharing of health care expenses by the insured and an insurer in a specified ratio;

(4) "Commissioner" means the Commissioner of Social Services;

(5) "Copayment" means a payment made on behalf of an enrollee for a specified service under the plan;

(6) "Department" means the Department of Social Services;

(7) "Eligible business" means a small employer, as defined in section 38a-564 of the general statutes, and includes, but is not limited to, a

municipality that has fifty or fewer employees;

(8) "Eligible individual" means a person who is nineteen years of age or older, has an income that exceeds one hundred per cent of the federal poverty level when income is calculated as provided in section 17b-261 of the general statutes, and is: (A) A self-employed individual (i) who works and resides in the state, (ii) who is organized as a sole proprietorship or in any other legally recognized manner, and (iii) whose primary source of income derives from a trade or business through which the individual has attempted to earn taxable income; (B) an unemployed individual who resides in this state; or (C) an individual employed in an eligible business that does not offer health insurance;

(9) "Enrollee" means an eligible individual who receives services from a managed care organization under the plan;

(10) "Plan" means the affordable health insurance plan established pursuant to sections 1 to 3, inclusive, of this act;

(11) "Managed care organization" means an entity that contracts with the department to offer a plan providing benefits to enrollees on a prepaid basis; and

(12) "Premium" means any required payment made by an enrollee to pay in full the capitation rate under the plan.

(b) The commissioner shall establish an affordable health insurance plan that shall, after start-up costs, be paid for by the enrollees, except as provided in subsection (d) of this section, through premiums and administrative services fees. An eligible individual may apply for enrollment in such plan if such individual (1) was uninsured as of January 1, 2005, or is employed by an eligible business, and (2) is uninsured on the date of the application for enrollment.

(c) Except as provided in subsection (d) of this section, an applicant for enrollment in the plan shall, at the time of application, be required

to pay a fifty-dollar application fee to the department. An enrollee shall, annually, upon reenrollment, pay a fifty-dollar enrollment fee and an administrative services fee to the department in accordance with the provisions of subsection (h) of this section.

(d) An eligible business may pay, on behalf of an employee, any fees or premiums charged to such employee who has enrolled in the affordable health insurance plan.

(e) (1) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the plan. The servicer shall enroll eligible individuals in such individual's choice of managed care organization. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the plan to the commissioner.

(2) The commissioner or, at the commissioner's discretion, the single point of entry servicer shall review applications for eligibility to determine whether applicants or employers of applicants have discontinued employer-sponsored coverage for the purpose of participation in the plan.

(3) An application may be disapproved if it is determined that an applicant was covered by an employer-sponsored insurance within four months prior to the date of application. If the commissioner determines that the time period specified in this subsection is insufficient to effectively deter applicants or employers of applicants from discontinuing employer-sponsored coverage for the purpose of participation in the plan, the commissioner may extend such period for a maximum of an additional two months.

(4) An application may be approved in cases where prior employer-sponsored coverage ended less than four months prior to the date of application, for reasons unrelated to the availability of the plan, including, but not limited to:

(A) Loss of employment due to factors other than voluntary

termination;

(B) Change to a new employer that does not provide an option for health benefits;

(C) Change of address so that no employer-sponsored coverage is available;

(D) Discontinuation of health benefits to all employees of the applicant's employer;

(E) Expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L. 99-272) as amended from time to time, (COBRA);

(F) Self-employment;

(G) Termination of health benefits due to a long-term disability;

(H) Termination of health benefits due to an extreme economic hardship on the part of either the employee or the employer, as determined by the commissioner; or

(I) Substantial reduction in either lifetime medical benefits or benefit category available to an employee under an employer's health care plan.

(f) The plan shall provide all benefits mandated by state or federal law. The commissioner may apply an exclusion for preexisting conditions, as permitted by federal or state law. The commissioner may impose lifetime or annual benefit maximums and limitations on the amount, duration and scope of benefits under the plan, and may establish a schedule of copayments and coinsurance for coverage provided under the plan.

(g) The commissioner shall require the payment of a premium in connection with services provided under the plan in accordance with the following limitations: (1) On or before September 1, 2006, and

annually thereafter, the commissioner shall establish a schedule for the maximum aggregate premium for individuals enrolling in the plan, and (2) the commissioner shall require each managed care organization to monitor premiums under the provisions of this section.

(h) (1) The administrative services fee shall be sufficient to cover the administrative costs of the plan and the outreach costs incurred pursuant to section 3 of this act. On or before August 15, 2006, and prior to the establishment of premium schedules for enrollees in the plan program for the first year, the commissioner shall calculate (A) administrative costs to be incurred by the department in the implementation and development of the plan, (B) the anticipated administrative costs for routine operation of the plan for the first year, and (C) an amount to be used to reimburse the General Fund for the first year for the start-up costs of the affordable health insurance plan administrative costs account established pursuant to section 2 of this act. On or before August 15, 2006, and annually thereafter, the commissioner shall calculate the anticipated administrative costs for routine operation of the plan for the year and an amount to be used to reimburse the General Fund for the year for the start-up costs of said account established pursuant to section 2 of this act.

(2) Administrative costs calculated by the commissioner pursuant to subdivision (1) of this section shall be paid for by moneys deposited in said account established pursuant to section 2 of this act.

(i) (1) On or before September 1, 2006, the commissioner shall enter into contracts with managed care organizations to provide the services described in subsection (f) of this section to enrollees in the plan. Such contracts shall require the establishment of an internal quality assurance plan by each managed care organization which shall be in writing and available to the public.

(2) Each managed care organization shall include sufficient numbers of appropriately trained and certified clinicians, including primary, medical subspecialty and surgical specialty physicians, as well as

providers of necessary related services to assure enrollees the option of obtaining benefits through such providers.

(3) Each managed care organization that enters into a contract with the department pursuant to subdivision (1) of this subsection to provide comprehensive services under the plan, shall have primary responsibility for ensuring that its behavioral health and dental subcontractors adhere to the contract between the department and the managed care organization, including the provision of timely payments to providers and interest payments in accordance with subdivision (15) of section 38a-816 of the general statutes. The managed care organization shall submit to the department a claims aging inventory report including all data on all services paid by subcontractors in accordance with the terms of the contract with the department.

(4) Upon the initial contract or the renewal of a contract between a managed care organization and a behavioral health or dental subcontractor, the department shall require that the managed care organizations impose a performance bond, letter of credit, statement of financial reserves or payment withhold for behavioral health and dental subcontractors that provide services under the plan. Any such performance bond, letter of credit, statement of financial reserves or payment withhold that may be required by the department pursuant to a contract with a managed care organization shall be in an amount sufficient to assure the settlement of provider claims in the event that the contract between the managed care organization and the behavioral health or dental subcontractor is terminated. Upon the initial contract or the renewal of a contract between a managed care organization and a behavioral health or dental subcontractor, the managed care organization shall negotiate and enter into a contract termination agreement with its behavioral health and dental subcontractors that shall include, but not be limited to, provisions concerning financial responsibility for the final settlement of provider claims and data reporting to the department. The managed care organization shall submit reports to the department, at such times as

the department shall determine, concerning any payments made from such performance bond or any payment withholds, the timeliness of claim payments to providers and the payment of any interest to providers.

(j) (1) The commissioner shall contract for the external quality review of the plan. Such review shall include, but need not be limited to, an evaluation of access to care, medical record standards, provider credentialing and individual case review.

(2) The commissioner may impose the following sanctions on any managed care organization which does not meet the quality of care required by regulations adopted pursuant to subsection (l) of this section or the standards developed for external quality review by a contract under the provisions of subdivision (1) of this subsection:

(A) Require the managed care organization to submit and implement a plan of correction;

(B) Limit new enrollment during any period of noncompliance;

(C) Withhold state payments that may become due until the deficiencies are corrected; or

(D) Prohibit the managed care organization from renewing or entering into new contracts to serve enrollees.

(k) Any payment made by the state on behalf of an enrollee as a result of any false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage by an applicant may be recovered by the state.

(l) (1) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, necessary to implement the provisions of this section, including, but not limited to, the establishment of residency requirements, methods for determining income eligibility for participation in the plan, procedures for a simplified mail-in application process, appropriate contract standards

to oversee and ensure the quality of care provided by managed care organizations under the plan, and criteria for assessing the outcomes of health care provided to enrollees in the plan.

(2) The commissioner shall implement the policies and procedures necessary to carry out the provisions of this section, while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal no later than twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

(m) On or before January 1, 2006, and annually thereafter, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance regarding the establishment and operation of the plan established by this section.

Sec. 2. (NEW) (*Effective from passage*) (a) There is established, within the General Fund, a separate, nonlapsing account to be known as the "affordable health insurance plan administrative costs account". Moneys received by the Department of Social Services pursuant to subsection (c) of section 1 of this act shall be deposited in the account. The account shall also contain any funds received pursuant to subsection (c) of this section. Investment earnings credited to the assets of the account shall become part of the assets of the account. Any balance remaining in the account at the end of any fiscal year shall be carried forward for the fiscal year next succeeding. The moneys in said account shall be used to pay for administrative costs incurred by the department through the development, implementation and routine operation of the plan and to reimburse the General Fund in accordance with subsection (b) of this section.

(b) On or before July 1, 2006, and annually thereafter, the Commissioner of Social Services, in accordance with the provisions of

subsection (h) of section 1 of this act, shall allocate a percentage of administrative fees to reimburse the General Fund for the start-up costs for the plan.

(c) The Commissioner of Social Services, subject to any limitations otherwise imposed by law, may receive and accept on behalf of the state for deposit in the account, any funds which may be offered or which may become available from federal grants or appropriation, private gifts, donations or bequests, or from any other source, for purposes of section 1 of this act.

Sec. 3. (NEW) (*Effective from passage*) (a) The Commissioner of Social Services, in consultation with the Labor Commissioner and the Commissioners of Economic and Community Development and Public Health, shall develop mechanisms for outreach for the affordable health insurance plan established pursuant to section 1 of this act, including, but not limited to, publicizing the availability of such plan, the eligibility criteria and how to apply for enrollment, development of mail-in applications and appropriate outreach materials through the Departments of Revenue Services, Social Services, Economic and Community Development and Public Health and the Labor Department.

(b) All such outreach materials shall be approved by the Commissioner of Social Services.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2005*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section

PH *Joint Favorable Subst. C/R* APP